Accreditation of Nursing Homes and Related Facilities

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IT WAS in the all too recent past that mention of a nursing home would conjure in the minds of most of us a picture of a rather ponderous and ornate structure whose designers had obviously had some far different domestic purpose in mind when it was built, the result being much makeshift and inconvenience when it was converted to its later humanitarian purpose. Yet it was at such an establishment that the convalescent, the chronically ill, the senile or the debilitated aged had to be taken care of if care could not be managed in his own home, at a relative's or possibly a nurse's house. Nursing care often was a labor of love, despite physical shortcomings, but sometimes left much to be desired. Actual experience of the patient, or observations by relatives or physicians, provided the only means of separating the good from the bad.

Problems in providing care for chronically ill persons have multiplied since World War II. As a result of changing economic forces and social habits, it has become more difficult for families, frequently with all adults employed, to care for the infirm, while at the same time the pronounced advancement in medical techniques has further widened the disparity between the care in general hospitals and home care facilities. So was born a great need for more and better establishments specializing in the care of long-term illness. The result of this was a steady increase in the number of nursing homes and related facilities—much of the increase being made up of large new units that were built for the purpose. Recent legislation providing for partial or complete payment of nursing home fees by government agencies has spurred the construction boom.

Because of the steadily increasing scope and importance of the chronic care facility, and because considerable qualitative differences develop when there is relatively sudden expansion in any field, it has been apparent for some time that a measuring method was needed so that a superior facility could be recognized, and also so that uniform standards could be set which could guide others in attaining a degree of excellence commensurate with modern medical and nursing advancements. This measure should augment and go beyond the requirements of licensure, which too often concern themselves with the appearance of the physical plant and pay little heed to the total care of the patient.

Interested parties noted the success which had attended the efforts of the Joint Commission on Accreditation of Hospitals to provide a standard of measure for the acute general hospital and the resultant improvement in hospital care in general. There were several attempts in various local areas in different parts of the United States to set up boards or groups concerned with similar improvement in long-term facilities. Some of these did well for a time, only to succumb to local or factional differences; others remained limited in scope. Also, there was interest on the national scale, particularly on the part of the American Nursing Home Association, but the very magnitude of the problem (and its cost) made progress agonizingly slow.

In California, little was accomplished before 1959. Then the California Joint Council to Improve the Health Care of the Aged, which had been created to appraise the available health resources for the aged and foster the best possible care for this group, recognized the important position nursing homes and related facilities occupied in providing for health care of old persons, many of them chronically ill. The Joint Council forthwith interested itself in the problem of improving the quality of long-term care. Many arduous hours over a period of nearly two years were spent by members of the Council in formulating a set of standards for these facilities by which comparisons could be made, specifically for the purpose of measuring, assaying and accrediting them. As the long experience of the Joint Commission on the Accreditation of Hospitals had resulted in a workable guide which had been used successfully throughout the United States for establishing and measuring hospital operation, the format of this body was adopted as a basis for the "Standards of Accreditation" set up by the group dealing with care of the aged. Modification was necessary, with deletion of the non-pertinent sections and the addition of items described jointly by the American Medical Association and the American Nursing

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Submitted August 3, 1962.

Home Association in the pamphlet *Guides for Medical Care in Nursing Homes and Related Facilities*, plus certain additions made by members of the Council itself.

After the Joint Council had completed its work on the Standards, it was necessary to implement them. It was for this purpose that the California Commission for the Accreditation of Nursing Homes and Related Facilities was created as a voluntary, non-profit organization composed of representatives from its supporting member organizations: the California Dental Association, California Hospital Association, California Medical Association, California Association of Nursing Homes, and the Southern California State Dental Association. By providing the Commission with a wide base composed of all these interested parties, it was hoped, as indeed has proved to be the case, to avoid intramural duplications, misunderstandings and the working at cross-purposes which had resulted in the downfall of many previous efforts. It was hoped also that placing the program on so wide a base would at once spread its benefits wider and avoid any purely local hindrances.

The first organizational meeting of the Commission was held February 21, 1961, in the meeting room of the California Medical Association building, San Francisco. Soon afterward it set about finding quarters and personnel. Money to inaugurate the program was obtained on loan from the Crocker-Anglo Bank, with the California Medical Association and the California Hospital Association acting as co-signers for four-fifths and one-fifth of the amount respectively. Then there were manuals to be formulated and surveying procedures to be worked before the actual surveying of facilities could start. By September 8, 1961, most problems seemed in hand and the chairman of the Joint Commission, Pierre Salmon, M.D., announced to interested facilities that the accreditation program was in operation and ready to accept applications.

It was evident that almost all facilities that applied early for accreditation were outstanding in their level of operation and were being managed by persons with a sense of responsibility and a feeling of confidence that they would be certified without difficulty. As time went on, however, there was an increase in the number of rejections as more facilities applied. As of May 31, 1962, 96 applications had been received by the Commission. Eighty-five facilities had been surveyed, of which 69, having 3,502 beds, had been granted full accreditation.

After the surveys had been under way for a time, changes in procedure and some revision and altered interpretation of the evaluation forms became necessary in the light of experience. By April, 1962, the Commission felt that it had gained sufficient knowledge to undertake a complete review of its standards, the better to tailor them to evaluating the long-term care facility. This review is still in progress. No doubt as the program continues to develop, further reviews and modifications will be indicated. It has also been necessary to revise some of the instructions to surveyors and make changes in the surveyors' manuals as experience has dictated.

The Commission evaluates a facility only upon request of the management. When it receives such a request, it first sends to the applicant information about the standards set forth by the Commission. Then within a reasonable time, by appointment, a surveyor calls. His report is reviewed by the entire Commission, which then may grant either full accreditation if the facility meets all standards, or provisional accreditation if it finds certain temporary deficiencies, or may deny accreditation if its standards are not met. Full accreditation is for a period of two years, provisional accreditation for one year. The right of appeal is provided for in cases of adverse decision.

In its survey the Commission stresses all phases of operation, with accreditation granted to the facilities providing overall excellence. Newness of the structure is not a governing factor. Considering the long-term care type of patient to be dealt with, emphasis is placed on superior nursing, happy, convenient and well-kept surroundings, programs for rehabilitation and recreation, and proper utilization of modern equipment and techniques. Requirements vary according to the type of facility: establishments registered as rest or boarding homes are not expected to offer the same services as those designated to provide skilled nursing care and more highly trained personnel.

Throughout the life of the Commission, it has been stressed that it is a voluntary organization set up to better the care of the chronically ill by helping the operators of private nursing homes or related facilities to improve the quality of care and the utilization of facilities. The Commission has no punitive function and no connection with any government body, but it is sometimes difficult to convince some of the more suspicious operators that the Commission's surveys are solely to help the facility attain higher standards. As the program continues to develop, its goals should become more obvious. Excellence is rewarded by the certificate of accreditation. It is the purpose of the Commission to show others how they may improve to reach the high standards which the certificate proclaims, and which it believes are necessary if the long-term patient is to get the kind of care of which we can be proud.

Generally, the Commission has been satisfied with the response to its program. As with any new en-

deavor, there has been some confusion and misinterpretation. The institution of the Medical Aid for the Aged Program caused certain complications, primarily because it was not immediately made clear what the requirements for participation in that program would be. This problem has now been settled.

The Commission plans to be self-supporting and to defray its expenses by making a charge for surveys. At present, pending actual cost experience, it is charging a flat fee of sixty dollars plus two and a half dollars for each licensed bed. While the charge may have deterred requests for surveys in some instances, it is probable that as the worth of the accreditation program becomes more apparent, more facilities may be expected to feel that this expense is justified.

Much of the potential value of the accreditation program has yet to be realized. As the superior facilities are recognized in increasing numbers, sheer economics will require that the sub-standard facility improve itself to survive.

Insurance covering long-term hospital care has long been a need, but insurance carriers have never had any means whereby they could assure themselves that the type of care to be provided would justify the cost. Conformance to a set of standards such as those set by the California Commission for the Accreditation of Nursing Homes and Related Facilities will assure both patient and insurance company that the accredited facility is giving them their money's worth. Already, certification of the acute general hospital by the Joint Commission on Accreditation of Hospitals has proven to be a reliable aid to insurance carriers seeking to obtain superior care for their policyholders. Carriers are now showing interest in the chronic care facility accreditation program.

The Commission's program will provide the medical profession with a yardstick which it can use in its quest for better patient care in chronic or custodial care institutions. Accreditation by the California Commission for the Accreditation of Nursing Homes and Related Facilities represents careful examination by a group of persons who are conversant in the fields of medical, dental, hospital, and nursing home care. The program is deserving of the full support of county medical societies and of individual physicians.

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